RECEIVED

JAN 18 2011

OFFICE OF INSPECTOR GENERAL

mailed validation letter 1/31/11

# Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 1.18.11
Amount $270.

Ck # 39736

## I. IDENTIFICATION

Name: Highlands Regional Medical Center

Address: PO Box 668

City/County/Zip: Prestonsburg Floyd 41653

Telephone number: 606-886-8511

Administrator: Harold C. Warman, Jr. FACHE

Date facility operation began at current address: January 1, 1997

Date facility began operation under current owner: January 1, 1997

## II. TYPE BEDS

| TYPE BEDS | No. beds licensed | No. beds requested |
|---|---|---|
| Skilled | | |
| Nursing Home | | |
| Nursing Facility | 18 | 18 |
| Intermediate Care | | |
| ICF/MR | | |
| Personal Care | | |

## II. CONTROL (check one in each column)

| | | |
|---|---|---|
| State | Profit | Individual |
| County | Nonprofit XX | Partnership |
| City | | Corporation XX |
| Private XX | | |

## II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

(OVER)

1/31

If facility owned or leased by a corporation, complete the following:

Name of corporation: Highlands Hospital Corporation

Address of corporation: 5000 KY RT 321, PO Box 668, Prestonsburg, KY 41653

President or Chairman: Edward R. Nairn

Vice President: Burl W. Spurlock

Secretary: Robert M. Duncan

Treasurer: Paul D. Nunn

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

| Parent | Management Company |
|---|---|
| Consolidated Health Systems, Inc. | |
| 5000 KY RT 321, PO Box 787 | |
| Prestonsburg, KY 41653 | |

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

| Signature of authorized representative | Title | Date |
|---|---|---|
| [signature] | President/CEO | 1-1-11 |

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)